Children's Special Health Care Services
Administrative Policy Manual

Benefit – Access to Care Policy # C-3b

Latest Revision Date: July 26, 2018

Effective Date:	**August 16, 1996**
Revision Reason:	**Updating Policies & Procedures to adjust to current trends in medical care.**
Incorporated:	**Reimbursement of Services for Children Enrolled in a Health Maintenance Organization (HMO)**
Effective Date:	**August 1, 1994**
Incorporated:	**Reimbursement of Services for Children Enrolled in a Preferred Provider Organization (PPO)**
Effective Date:	**February 1, 1995**
Incorporated:	**Retroactive Authorization of Services Rendered while CSHCS Application Pending**
Effective Date:	**July 1, 1993**

Title: **Prior Authorization**

Prior Authorization Procedure

Purpose: **To ensure access to appropriate care, as provided by CSHCS, is provided to all participants within the Children's program.**

Rule References:

410 IAC 3.2-7-2 Basic services included in the health care services package
410 IAC 3.2-7-3 Limited health care services included in the health care service package

Policy: **Prior Authorization (PA) is required for all health care services (except for certain outpatient related services as noted below, for providing requested medical records and for services authorized via a Linkage). Emergency Services may be submitted for authorization retroactively by the health care provider to ensure that the treatment was truly a situation requiring emergency treatment and that the treatment was related to the participant's eligible medical condition. Emergency health care services failing those tests will not be paid by CSHCS.**

A PA is required for the following health care services:

- **Ambulance**

- **Emergency Services – (defined above)**
- **Inpatient Services**
- **Surgery/Recovery Room (Inpatient or Outpatient based)**
- **Dental Services (Orthodontia)**
- **Durable Equipment & Supplies (DME)**
- **Therapy Services**
- **Medications costing $1,000 or more**
- **Nutritional Supplements, Formula & Vitamins**

The following Outpatient based services do not require Prior Authorization as they will have been ordered by a provider authorized to treat the participant via a Linkage or Referral:

- **Audiology (hearing tests except when general anesthesia is required.)**
- **Laboratory and the professional component related to interpretation thereof**
- **Radiology and the professional component related to interpretation thereof (X-Rays, CT scan, EKG, EEG, MRI, spirometry, ultrasound echocardiogram, etc., except when general anesthesia is required)**
- **General medical/surgical supplies billed with radiology or laboratory services**
- **Other procedures as may be exempted from Prior Authorization by CSHCS.**

Drugs and medications requiring a prescription under Indiana or federal law that are medically necessary for treatment or control of any medical conditions affecting a participant need if the drug cost is $1,000 or more requires a Prior Authorization.

The health care provider is responsible for requesting authorization & the provider will not be reimbursed unless the service was authorized by CSHCS.

Linkage of a participant to a Primary Care Provider is equivalent to an open PA for health care services contained within the Basic Health Care Services Package, which are rendered to the participant by that provider within that provider's office or facility.

Linkage of a participant to a Specialty Care Provider is equivalent to an open PA for health care services related to the participant's eligible medical condition, which are rendered to the participant by that provider within that provider's office or facility.

A PA is required for all referrals from a Primary or Specialty Care provider to another health care provider (specialist, therapist, etc.). The referred-to provider is responsible for obtaining Prior Authorization for any services beyond those originally authorized.

Limitations:	**Generally, a PA has limitations:**	**Limitation**
	Referral to another health care provider	**Date or date-range specific**
	Ambulance	**Date or date-range specific**
	Emergency Services	**Date or date-range specific**
	Inpatient Services	**Date or date-range specific**

❑ **Outpatient Services**	**Date or date-range specific**
❑ **Surgery/Recovery Room**	**Date or date-range specific**
❑ **Dental Services (Orthodontia)**	**Treatment Plan duration**
❑ **Durable Equipment & Supplies**	**Purchase or # of months rental**
❑ **Therapy Services**	**# of treatments or # of months**
❑ **Medications costing $1,000 or more**	**Date, date-range, valid script**

A date or date-range specific (duration-based) PA will normally be issued for more than six (6) months. Orthodontia, treatment for certain chronic illnesses, ongoing Out-Patient infusion services & services not yet schedulable, being the more notable exceptions.

Retroactive Authorizations will be issued to providers for covered health care treatment related to the participant's eligible medical condition, which was rendered between the Application Date and the State Action Date when an applicant is approved as eligible to participate in the Children's Program.

See the Travel Policy for appropriateness of Travel reimbursement.

If a participant also has Medicaid Coverage:

Generally, as the payer of last resort, CSHCS would only be responsible for co-payment amounts on Medicaid covered services and for services covered by CSHCS, which are not covered by Medicaid. CSHCS does <u>not</u> cover any Medicaid Spenddown amount the participant is required to pay each month before their Medicaid benefits are available to them, because this amount is considered part of the participant's eligibility requirement for Medicaid benefits.

It is a CSHCS Standard Operating Procedure (SOP) not to issue a Prior Authorization for services when a participant also has Medicaid, unless CSHCS has been provided a letter of denial from Medicaid stating a valid reason for denial.

- **Valid reasons would generally be that a service was not a Medicaid covered service or the maximum utilization of a Medicaid benefit had been reached.**
- **Invalid reasons are generally issued when the participant or the provider did not follow required procedures or use the proper codes when billing.**

If a participant also has Commercial Insurance Coverage:

Often, multiple providers are involved in a specific treatment of a participant, as is the case when a physician utilizes facilities and services of an institution, such as a hospital or surgical center. CSHCS only issues PAs to CSHCS providers. More often than not, hospitals and surgical centers will be a CSHCS provider. Usually, the primary provider treating a participant will belong to the insurance company's "Network" and may or may not be a CSHCS provider.

Whether their insurance coverage is through an Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or some other insurance model, for CSHCS coverage to apply the participant must comply with all requirements for receiving benefits pertinent to their insurance coverage, to include requesting referral to specialists, Prior Authorization, Pre-certification of hospitalization, utilizing the providers available within the insurance company's provider networks,

and utilizing the insurance company's grievance or appeal procedure, if a service or referral is refused or denied. This requirement may be waived in an emergency situation, or if the participant or family is dissatisfied with the care of the insurance company-approved health care provider or is unable to obtain a referral or other authorization, by the Director, Maternal & Children's Special Health Care Services, or their designee. In such situations, CSHCS will provide for a second opinion, or referral to Riley Hospital or a local CSHCS approved specialist for diagnostic examination and/or treatment of an eligible medical condition.

References:
Primary Medical Care Policy
Secondary Medical Care Policy
Basic Dental Care Policy
Dental Services Policy
Durable Medical Equipment (DME) Policy
Exclusions from Coverage Policy
Linkage Policy
Therapy Policy
Travel Reimbursement – when Authorized Policy